

Appendix 5

Sample HCFA 1500 Claim Form-Medical Direction With Qualifying Circumstances

HEALTH INSURANCE CLAIM FORM										PICA <input type="checkbox"/>																																																																																																																																															
<div style="display: flex; justify-content: space-between;"> <div> <div> <input type="checkbox"/> PICA </div> <div> <input type="checkbox"/> MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER (ID) </div> </div> <div> 1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) 1234567890 </div> </div>																																																																																																																																																									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Recipient, Im A.					3. PATIENT'S BIRTH DATE MM DD YY SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F																																																																																																																																																				
5. PATIENT'S ADDRESS (No., Street) 609 Willow					6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>																																																																																																																																																				
CITY Anytown			STATE WI		CITY 			STATE 																																																																																																																																																	
ZIP CODE 55555			TELEPHONE (Include Area Code) (XXX)XXX-XXXX		ZIP CODE 			TELEPHONE (INCLUDE AREA CODE) ()																																																																																																																																																	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) OLP					10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO																																																																																																																																																				
a. OTHER INSURED'S POLICY OR GROUP NUMBER 					a. INSURED'S DATE OF BIRTH MM DD YY SEX <input type="checkbox"/> M <input type="checkbox"/> F																																																																																																																																																				
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX <input type="checkbox"/> M <input type="checkbox"/> F					b. EMPLOYER'S NAME OR SCHOOL NAME 																																																																																																																																																				
c. EMPLOYER'S NAME OR SCHOOL NAME 					c. INSURANCE PLAN NAME OR PROGRAM NAME 																																																																																																																																																				
d. INSURANCE PLAN NAME OR PROGRAM NAME 					10d. RESERVED FOR LOCAL USE 																																																																																																																																																				
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.																																																																																																																																																									
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____																																																																																																																																																									
14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)					15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY																																																																																																																																																				
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE 					17a. I.D. NUMBER OF REFERRING PHYSICIAN 																																																																																																																																																				
19. RESERVED FOR LOCAL USE 					20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO																																																																																																																																																				
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. 575 1 2. 284 8 3. _____ 4. _____					22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. _____ 23. PRIOR AUTHORIZATION NUMBER 																																																																																																																																																				
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th colspan="3">A DATE(S) OF SERVICE From To</th> <th colspan="2">B Place of Service</th> <th colspan="2">C Type of Service</th> <th colspan="2">D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER</th> <th>E DIAGNOSIS CODE</th> <th>F \$ CHARGES</th> <th>G DAYS OR UNITS</th> <th>H EPSDT Family Plan</th> <th>I EMG</th> <th>J COB</th> <th>K RESERVED FOR LOCAL USE</th> </tr> </thead> <tbody> <tr> <td colspan="3">MMDDYYYY</td> <td colspan="2">1</td> <td colspan="2">7</td> <td colspan="2">47600 W2</td> <td>1</td> <td>XXXX</td> <td>8.0</td> <td></td> <td></td> <td></td> <td>12345678</td> </tr> <tr> <td colspan="3">MMDDYYYY</td> <td colspan="2">1</td> <td colspan="2">7</td> <td colspan="2">99135</td> <td>2</td> <td>XXXX</td> <td>1.0</td> <td></td> <td></td> <td></td> <td>12345678</td> </tr> <tr><td colspan="16"> </td></tr> <tr><td colspan="16"> </td></tr> <tr><td colspan="16"> </td></tr> <tr><td colspan="16"> </td></tr> <tr><td colspan="16"> </td></tr> <tr><td colspan="16"> </td></tr> </tbody> </table>										A DATE(S) OF SERVICE From To			B Place of Service		C Type of Service		D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		E DIAGNOSIS CODE	F \$ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE	MMDDYYYY			1		7		47600 W2		1	XXXX	8.0				12345678	MMDDYYYY			1		7		99135		2	XXXX	1.0				12345678																																																																																																
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25. FEDERAL TAX I.D. NUMBER 			SSN EIN 		26. PATIENT'S ACCOUNT NO. 1234JED			27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ XXX XX		29. AMOUNT PAID \$ XX XX		30. BALANCE DUE \$ XX XX																																																																																																																																											
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) I.M. Authorized MM/DD/YY SIGNED _____ DATE _____					32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office) 					33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # I.M. Billing 1 W. Williams Anytown, WI 55555 87654321 PIN# _____ GRP# _____																																																																																																																																															

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 5/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500